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Research Deliverable 4.2

Administrative Simplification Initiatives

Overview of Selected Administrative Simplification Initiatives and Potential State Actions for Support

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Executive Summary

Washington State's HRSA-funded State Planning Grant on Access to Health Insurance includes a focus on administrative simplification and initiatives that may contribute to improving efficiencies and reducing costs due to administrative overhead. The impetus for this focus is documented evidence that the burden of administrative overhead is increasing and that the resulting costs—both in dollars and reduced availability of providers—might be addressed through targeted initiatives. The project sought to gather information on efforts to achieve administrative and infrastructure changes that may help reduce administrative burdens, moderate increases in health care costs, and (at least indirectly) provide more accessible coverage. In particular, the project sought to identify broad collaborative administrative efficiency efforts within the private sector that might positively affect public sector care.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team. The report presents the literature review, targeted inventory, Technical Advisory Group summary, and analysis undertaken to assess administrative simplification initiatives in the private health care community and opportunities for private-public partnerships. The report includes discussion of the potential for a state role in the partnership initiatives and possible barriers to state participation or implementation of these initiatives in the public sector.

As the consultant team carried out its research and worked with State Planning Grant staff and the Administrative Simplification Technical Advisory Group (TAG), several themes began to emerge. These were most clearly expressed during the project's Technical Advisory Group meeting. Although TAG members supported public-private collaborative efforts, some noted that the private sector perceived a need for collaboration within and between public agencies that should precede efforts to undertake external collaboration with private sector partners. TAG members also noted that state agencies might enhance their business relationships and promote successful future public-private sector collaborative efforts by ensuring that state agencies "speak with one voice." TAG members expressed enthusiasm for a demonstration of state leadership that signaled a readiness to participate in the collaborative development of creative solutions to shared administrative simplification challenges. Finally, the TAG did not support regulation or a mandate for a single technology at this time.

Three areas of possible state action merit further evaluation:

1. Support the efforts underway by the CEO Forum, Washington Health care Forum Services, and their Network Advisory and Administrative Simplification Groups to design and implement electronic and other administrative process improvements that simplify

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information exchange and business processes between health plans and providers. Examples include:

- Electronic claims processing and payment
- Electronic eligibility verification
- Simplifying credentialing processes
- Secure electronic communications

This coalition of private payers and providers represents a significant portion of the private sector health care services in Washington State. More importantly, the participants carry sufficient weight by virtue of their positions as CEO and CEO-designated representatives that they are able to commit their organizations to action when appropriate. Similar organizations in other states have found a role for their public sector health care partners.

2. Create a way to "speak with one voice" to the private community regarding administrative issues. The state plays an important role in addressing administrative burdens and reducing costs and overhead for both payers and providers. The state purchases medical care and services through the Department of Social and Health Services' Medical Assistance Administration (MAA), the Health Care Authority, and the Department of Labor and Industries, as well as other agencies. Although examples of inter-agency collaboration exist, each agency follows its own unique business policies, processes, and information systems—in part to address federal and state laws and regulations unique to each agency and its programs. These multiple business systems and processes, as well as the sheer size of these agencies as payers, create significant burdens for providers.
3. As a specific example of leadership and action to advance system change, investigate implementation of a claims adjudication threshold within state agencies. This effort would eliminate prospective claims adjudication below a defined threshold, reducing administrative burden for providers and promoting prompt provider payments. Prompt payment turnaround might enable many routine or low-cost health care business transactions to operate much like non-health care businesses—for example, the use of debit and credit cards for most routine retail purchases—and reduce administrative burdens for providers. This reduction in administrative costs and burdens, along with improvements in prompt payment turnaround, may positively affect provider participation in public programs, such as Medicaid or Healthy Options.
4. Each of these areas requires varying degrees of additional investigation to determine the efficacy of implementation, and its statutory, regulatory, financial, and administrative feasibility. The inventory and input from the private sector represents a small, but potentially significant, first step.

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Background

The U.S. Health Resources and Services Administration State Planning Grants are designed to enhance each state's ability to understand their uninsured population and their health care needs and to make strides toward devising plans and initiatives to improve access. Unique to Washington's proposal to HRSA was the inclusion of an investigation of the initiatives aimed at simplifying the administration of health care treatment, payment, and operations. The desire to look more closely at initiatives and pursue public-private opportunities for collaboration is based on sound evidence that administrative hassles have significant negative effects—in cost, in quality and in access. For example, at the national level, The Center for Medicare and Medicaid Services estimates that administrative payments for the Medicaid program alone have grown 77 percent, from $3.9 billion to $6.9 billion, between 1991 and 1998 (www.hcfa.gov/medicaid/msis/2082-1.htm).

The increasing burden of administrative overhead is taxing the delivery of health care from both financial and patient care standpoints. Resources consumed by administrative requirements are not available for services, and providers and patients alike experience administrative overload and avoid or drop out of the system. Publicly and privately insured individuals and their providers struggle with eligibility verification, pre-authorization, and claim payment procedures, as well as provider network requirements and changes. In publicly funded programs low provider payments may not offset the cost of doing business for this patient population. The beneficiaries of these programs are challenged with a sometimes bewildering variety of rules and policies making the choice to enroll and re-enroll in public programs overwhelming.

Recognizing these burdens, the 1996 Health Insurance Portability and Accountability Act (HIPAA) included administrative simplification requirements. The express purposes of these provisions are to "improve the Medicare and Medicaid Programs in particular and the efficiency and effectiveness of the health care system in general by encouraging the use of electronic methods for transmission of health care information through the establishment of standards and requirements for covered electronic transmissions." (National Center for Vital Health Statistics First Annual Report to Congress, http://66.70.168.195/yr1-r01.htm). The Electronic Data Interchange (EDI) standards along with privacy and security standards are designed to diminish the administrative burden of delivering health care. Though HIPAA has become the industry shorthand for administrative simplification, these rules touch on only a small part of the burden felt by the health care community and its beneficiaries.

In Washington State, efforts have been launched in the private and public sectors and include initiatives spearheaded by the Washington State Hospital Association, Washington State Medical Association, Foundation for Health Care Quality/CHITA, Washington Health Foundation, Pointshare, federal Health Care Financing Administration (now The Center for Medicare and

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Medicaid Services), and other public and private organizations. Still, in a 2001 study of health care for low-income rural patients in Washington State, providers indicated an increasing unwillingness to participate in public programs and cited administrative hassles as a factor in their decisions (www.academyhealth.org/abstracts/2001/access/katz.htm). Other studies corroborate this finding and its broader effects throughout the health care system.

Purpose

The Washington State Planning Grant on Access to Health Insurance includes a focus on administrative efficiency approaches, tools, and partnerships. The health care system in Washington State, and the U.S. as a whole, is highly fragmented and complex, which has two general effects. First, it leads to inefficiencies in service delivery, data collection and transmission, and administrative functions, which wastes scarce resources. Second, the complexity frustrates users of services, purchasers of insurance, and providers, alike, to the point where they may decide to delay or avoid seeking needed services, not obtain coverage that is available to them, or not provide care to certain types of patients, thus creating access problems. So, efficiency and administrative simplification have at least an indirect relationship to health insurance coverage and access.

Scope

The Washington State Planning Grant sought to gather information on efforts to achieve administrative and infrastructure changes that could lead to improvements in the health system. In particular, the project sought to identify broad collaborative administrative efficiency efforts within the private sector that might positively affect public sector care. The report includes discussion of the potential for a state role in the initiatives and the possible barriers to state participation or implementation of these initiatives in the public sector. This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team

The scope of the administrative simplification component includes a targeted inventory and an identification of initiatives underway or of primary interest to the private sector, with an eye toward identifying broad collaborative efforts in which the state might lend support or play a role. The initial inventory of private efforts included:

- What efforts and issues are under consideration
- Who is leading or participating in various efforts
- How the issues are being examined and prioritized
- Key constraints

The inventory focused on billing and payment initiatives, information and data transmission activities, and other health care operation issues seen as burdensome by patients and providers. The scope was limited to private sector initiatives within Washington State and did not include public sector initiatives. The inventory focused on initiatives that target administrative processes in particular and did not include initiatives aimed at clinic and care management practices. In addition, a review of the literature documented other states' and organizations' initiatives.

The balance of this document presents the findings and implications of our investigation of administrative simplification initiatives. First, we describe the methods for creating the inventory

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of initiatives, convening a technical advisory group, and identifying opportunities for private-public collaborations. We then describe three potential areas for state involvement that grow out of this analysis.

Methods

The administration simplification initiatives component of the Washington State Planning Grant on Access to Health Insurance included four major activities: a *high-level review of literature* concerning administrative simplification efforts, particularly public-private collaborations in several other states, and studies that document the effects of administrative burdens; the *development of an inventory* of Washington State initiatives in the private sector; the *convening of a technical advisory group* (TAG) to further refine the understanding of the initiatives and barriers; and the *identification of opportunities* for private-public collaboration.

Literature Review

A high-level literature review was undertaken with two purposes: 1) to identify other, particularly statewide, initiatives that merited closer attention; and 2) to document the connection between administrative burdens and access to care.

The review of literature revealed two states that have undertaken efforts that could provide lessons for Washington. Both Utah and Minnesota have established unusual private-public associations designed specifically to address the administrative burdens of interest in this study. More details of these initiatives are described in the Findings section below.

The companion reports Research Deliverables 4.4 *Community Access Initiatives* and 4.3 *Options for Distilling the Current Array of Washington State Medical Benefits* reports discuss various issues concerning administrative burdens in the health care system. We did not duplicate those efforts, but augmented them by researching the following sources. The resulting annotated bibliography is included in Appendix A.

Academy for Health Services Research and Health Policy

Centers for Medicare and Medicaid Services (CMS)

Coalition for Affordable Quality Health care

Commonwealth Fund

Foundation for Health Care Quality/ Community Health Information Technology Alliance

Health Care Advisory Board

Institute of Medicine

Joint Center for Political and Economic Studies

Kaiser Family Foundation

North Carolina Health care Information and Communication Alliance

Urban Institute

Western Governors' Association

Miscellaneous publications of interest

Targeted Inventory Development

The development of the targeted inventory began with a scan of the environment for private sector initiatives underway or being considered to decrease the burden of the administration of health care services. The team then identified a group of individuals at various private and quasi-public health care organizations throughout the state. The group was selected to represent a diversity of geographic regions and health care settings, such as private clinics, health plans,

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state medical and hospital associations, and practice management organizations. Representatives of the following organizations were contacted:

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American Association of Health care Administrative Management, Inland Chapter

American Association of Medical Administrators

CEO Forum's Administrative Simplification Steering Committee (ASSC)

Choice Regional Health Network

Community Health Plan of Washington

Community Physician Administrative Support Service (ComPASS)

Inland Northwest Health Services

Medicare/Noridian

Providence Medical Center, Yakima/Toppenish

Sports Medicine Clinic, Ballard

Transaction Payment Network

TRICARE NW, Department of Defense

Washington State Hospital Association

Washington State Medical Association

Washington State Medical Group Management Association

Wenatchee Community Choice

Yakima Valley Farm Workers Clinic

Fourteen people representing seventeen organizations—some individuals spoke both from their role at their workplace and their role in an association or committee—were contacted. We interviewed each using a protocol containing questions designed to learn about their initiatives or their concerns. The length of interviews, which were conducted primarily by telephone, ranged from 24 to 72 minutes.

The complete interview guide is included in Appendix C.

Technical Advisory Group and Follow-Up Interviews

Once the interview data were gathered and synthesized, a technical advisory group (TAG) was convened to help us further understand the potential state participation and support of initiatives. The original interviewees were invited along with representatives of state agencies and a few additional private organization participants. The attendees included representatives from the Washington State Hospital Association; Washington State Medical Association; PointShare; Choice Regional Health Network; National Federation of Independent Business; Foundation for Health Care Quality; Sierra Systems; Providence; COMPASS; Transaction Payment Network; Medicare/Noridian; Medical Assistance Administration; State Health Care Authority; State Department of Labor and Industries; State Board of Health; State Office of Insurance Commissioner; State House of Representatives; Governor's Health Policy Office; and the State Planning Grant Office.

The questions and discussion items posed to the group were:

1. Which initiatives/areas of simplification are the most viable for a private-public collaboration?
2. Is there value in pursuing collaboration? Why or why not?
3. Which initiatives or areas of simplification should be the highest priority for collaboration?
4. Why? (What criteria should be used to decide viable initiatives and priority initiatives?)
5. What are or will be the issues and barriers to successful collaboration?
6. How can such issues or barriers be addressed?
7. What "lack of knowledge" makes addressing these issues difficult? (What additional data are needed?)
8. What key messages summarize your thoughts regarding Administrative Simplification Initiatives and potential private-public collaboration?

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9. What strategies would you suggest for moving the conversation forward?

Follow-up discussions were held with the Pointshare representative, the Washington State Hospital Association representative, and a technical expert on security transactions to clarify new information gained in the TAG meeting.

Identification of Opportunities

The findings from the interviews, the TAG, and follow up discussions were used to help identify potential opportunities for public-private collaboration. Many issues and individual site initiatives exist, all of them important to the providers, payers, and patients they targeted. The Washington State Planning Grant's Request for Proposal indicated an interest in "broad collaborative administrative efficiency efforts with identification of barriers and potential state roles." Using these guidelines, the consultant team analyzed the input from the interviews and meetings and identify specific opportunities for further evaluation and support.

Findings

Literature Review

An annotated bibliography in Appendix A provides sources for articles and information relating to administrative simplification. Most of these sources are specific to initiatives taken to reduce the burden of administrative overhead. The bibliography also includes references that document the connection between administrative costs and access to care.

Our review of the literature revealed two statewide initiatives in other states that appeared to be consistent with the State Planning Grant's interest in broad collaborative efforts. The first, The Utah Health Information Network (UHIN) **(**www.uhin.com**)**, is a private-public collaboration targeting administrative simplification. Formed in 1994, its mission is to provide the consumer of health care services with reduced costs and improved health care quality and access, and to facilitate research by:

- **Creating and managing an electronic value-added network** to link members of the health care community in Utah for the purpose of interchanging important financial and clinical information
- **Standardizing** health care transactions and health care reporting, electronic interface development, and communication services
- **Gathering and providing data** to a statewide data repository

UHIN's members—payers, providers, and state agencies—include such organizations as Intermountain Health Care, University of Utah Health Sciences Center, Regence Blue Cross/Blue Shield of Utah, Public Employees Health Program, and Utah Medical Association, among others. UHIN, a not-for-profit corporation initiated with funds from member organizations and the state of Utah, charges "reasonable" fees for its services.

A second successful and relevant model exists in Minnesota. The Minnesota Center for Health care Electronic Commerce (MCHEC), a division of the Minnesota Health Data Institute, is "dedicated to promoting the use of health care electronic commerce in Minnesota" (www.mhdi.org/mchec/mission.html). MCHEC was formed in 1998 as a member alliance of private and public organizations, including: Blue Cross/Blue Shield of Minnesota, Mayo Clinic,

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United Health Care, Minnesota Department of Health, and the Minnesota Department of Labor and Industries, among others. MCHEC is involved in the Minnesota HealthKey Project to develop Public Key Infrastructure (PKI) approaches within the health care system in their state. PKI refers to a secure method of encrypting and moving data electronically.

The HealthKey Minnesota project seeks to promote the presence of the following requirements for electronic communication to flourish across the health care sector:

- Standards for electronic transactions
- Reliable and accountable electronic networks
- A security framework for the electronic exchange of information

MCHEC is also collaborating with another HealthKey project in North Carolina and with private vendors to ensure inter-operability among private and public health care organizations (www.healthkey.org).

The scope of collaboration and activities of these two models made them particularly relevant to the State Planning Grant project. Similar efforts have been launched in Washington State under the auspices of the Foundation for Health Care Quality (FHCQ) and its Community Health Information Technology Alliance (CHITA). CHITA has spearheaded a series of forums designed to educate health care organizations, both public and private, about upcoming HIPAA requirements. A HealthKey initiative in Washington paired the Washington State Department of Health and CHITA in a PKI initiative to transmit data from public health laboratories to the state.

The CEO Forum was created in Washington State to promote partnerships to improve health care operations across the state. The Forum brings together key leaders and staff from private sector payer and provider organizations to design solutions that de-emphasize traditional competitive roles and promote collaboration and mutual success in streamlining business processes and other activities. This coalition formed an Administrative Simplification Steering Committee and a business arm, Washington Health care Forum Services, that are taking vigorous action to address administrative and technology shortfalls. The Washington State private sector efforts are discussed in greater detail under Opportunities.

We also reviewed programs in other states and organizations. For example, the Western Governors' Association has sponsored a pilot demonstration of smart card technology in its Health Passport Project (HPP) being conducted in North Dakota, Wyoming, and Nevada. The HPP cards are designed to "manage data and benefits from a variety of public health programs including: Head Start; Women, Infant, and Children; Medicaid; immunizations; and other maternal and child health services" (www.westgov.org/wga/press/hpp_rpt.htm). The Urban Institute's independent assessment of three years of the HPP pilot recommends careful expansion of the program incorporating new technologies. They found that the pilot demonstration had proven the conceptual foundation of the project: "the viability of interagency cooperation and the secure sharing of critical client information across multiple systems" (http://www.westgov.org/wga/initiatives/hpp/hpp_sum2.pdf).

The Coalition for Affordable Quality Health care is developing a single source credentialing system to reduce the overhead of the credentialing process for providers and payers (http://www.caqh.org/whatwedo_simplify2.html). This coalition of twenty-six of the largest health plans and insurers in the U.S. will store more than 600,000 providers in its nationwide database. One of the intended benefits of the streamlined credentialing is that providers will complete only one credentialing application instead of the typical 10 to 20 they must now face.

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Two references summarize the correlation between administrative burdens and access to care. *The Primary Care Provider Study*, conducted in 2000-2001 for the Washington State Legislature (HPAP 2001), found that "the delivery system for Washington state's Medicaid and Basic Health programs is weakening and threatens reduced access to care for low-income Washingtonians. Low payments from these programs to providers coupled with substantial administrative burdens are factors in the destabilization of rural primary care delivery systems, and providers are beginning to pull back from participation in these programs as a result" (www.academyhealth.org/abstracts/2001/access/katz.htm).

A second study examines access from the patient's perspective. A study for The Robert Wood Johnson Foundation's State Coverage Initiatives program assessed the potential of the Internet to streamline Medicaid and CHIP applications. It found that 21 percent of parents of uninsured children reported they could not complete the enrollment process largely because of barriers obtaining the paperwork and complicated enrollment processes (www.statecoverage.net/pdf/scinews0700.pdf). A separate study by authors at The Urban Institute, using data from the 1999 National Survey of America's Families showed "that administrative hassles were a primary barrier to enrolling … 10 percent of low-income uninsured children" (http://www.urban.org/template.cfm?Template=/TaggedContent/ViewPublication.cfm&PublicationID=7233).

Targeted Inventory of Select Private Sector Administrative Simplification Initiatives in Washington State

The inventory of administrative simplification efforts in Washington was created through interviews with representatives of diverse organizations across the state followed by a meeting of the Technical Advisory Group and other discussions. Interviewees and participants were enthusiastic about sharing their issues regarding the administrative burdens of health care delivery and their ideas about relieving these burdens.

Despite many common concerns, we found few broad initiatives actually underway. Proactive people within organizations are taking steps to relieve some of the burden under their control. Examples of such organization-specific initiatives include: development of electronic claims transactions and eligibility/enrollment processing; data warehousing for quality assurance/utilization review, HIPAA guidance and training; and systems for making on-line appointments. A number of organizations have established their own Virtual Private Networks (VPN), a way to communicate securely across locations, or they have outsourced this function. Many people we talked with voiced concern about secure electronic transaction and communication capability.

Some organizations are addressing the administrative burdens by outsourcing communications and administrative applications. Pointshare, a Bellevue, Washington-based corporation, offers commercial services nationwide that automate health care business operations. These services include eligibility checking, coding, claims, and referrals among others. Several organizations contacted during the interviews are using Pointshare services to streamline their existing practices.

Issues identified by a number of interviewees included the training burden and resulting staffing costs related to the mix of administrative requirements and the inconsistent interpretation of rules. The credentialing process was cited as a barrier to expeditious care and reimbursement.

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When asked what role the state might play in relieving the administrative burden or participating in the initiatives, enthusiasm among interviewees was noticeably lacking. Several people argued the state has increased, rather than decreased, the administrative burden since the onset of managed care. In addition, the credibility of state government has suffered since what some perceive as the failure of "prompt pay" legislation. A majority of interviewees expressed frustration with the multiple players involved in health care across state agencies and emphasized that this "lack of one voice" contributed to administrative burdens. The strongest request we heard from those we talked with was some variation of "the state needs to speak with a single voice."

Interviewees offered other suggestions for action. These included development of a state claims data warehouse by a designated state agency. The data warehouse would collect state claims data and return the appropriate data to the originating provider, promoting more complete quality assurance and continuity of care datasets at the provider level. Another proposal suggested a state-sponsored analysis of the health-care sector's communication needs in order to promote efficiencies in care delivery and administrative processing. Interviewees expressed consistent frustration with the credentialing process. Some advised developing a statewide provider database as a potential step toward addressing the inconsistencies and duplications in this process. Finally, interviewees suggested that the state establish a common certification and authentication mode for secure communications as a possible mechanism for improving system-wide interactions .

We spoke with representatives of the CEO Forum and its Washington Health care Forum Services, representing multiple payers, providers, and purchasers. This coalition has taken steps toward standards and approaches for electronic communication through its Network Advisory Group. The Forum's Administrative Simplification Steering Committee (ASSC) has a well-structured process in place for addressing administrative issues and approaches. More details regarding the CEO Forum and its initiatives are discussed in greater detail in the Identification of Opportunities section of this report.

The consultant team clustered the administrative issues or initiatives identified through the interviews and other discussions into categories. After categorization, the consultant team also identified the administrative burden and benefit the issues or initiatives were designed to address.

Figure 1 presents a summary of select initiatives.

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Figure 1. Summary of Select Private Sector Administrative Simplification Initiatives (in alphabetical order)

Administrative Simplification Initiative	Description	Administrative Burden	Purpose or expected Outcome	Comments
Data warehousing	Some organizations have begun warehousing data regarding patient treatment where they have the capability. Interviewees expressed an interest in receiving state claims data for a more complete dataset.	Patient data may reside in multiple places within an entity and across the health care system. This makes it difficult for organizations to assess the quality and continuity of care provided and the health of their insured population.	Analysis of care on a macro basis to improve quality across an organization and the health status of the population. Analysis of care at the patient level to improve continuity of care and potentially affect outcomes.	The data warehousing efforts are, in some cases, a less sophisticated attempt to get to the same end , i.e. an electronic record of treatment.
Electronic claims transactions	Several organizations are developing their own internal electronic claims capability. Others are outsourcing this function to clearinghouses or other vendors.	Processing claims manually slows reimbursement time and may require multiple submissions for completeness. Resolving claims of state-supported beneficiaries often requires multiple agency involvement	Reduced denial of claims and improved cash flow	One interviewee referred to the process as "passing bucket brigades of data around" and found it amazing that claims ever got successfully settled. While a number of organizations have automated their claims processes internally, many pockets of incompatibility between computer systems remain, as do requirements for manual filing. Managed care, in the form of the state's Healthy Options program, is seen by some as having decreased the electronic filing of claims that had existed with the state and increased manual filing required by multiple plans. Though electronic submissions do not guarantee correct entries or immediate acceptance and payment, electronic filing can provide online edits and faster transmission/turn-around time.
Electronic enrollment and eligibility checking	Online checking of patient eligibility and online filing of enrollment forms and documentation. Some organizations contract with commercial vendors e.g. Pointshare for electronic enrollment and eligibility.	Determining eligibility is particularly problematic for low-income patients, those often supported by state programs. Their income levels may vary from month to month, and the documentation required may be confusing. The requirements across state programs are not consistent, creating another layer of misunderstanding When eligibility is unknown, care may be delayed or reimbursement denied. Processing enrollment forms and documentation in person or by mail is slow and cumbersome.	Greatly increased enrollment of beneficiaries of both public and private programs. Reduced denial of claims. Improved access and treatment.	Several specific examples of how online enrollment and eligibility improved care were provided by interviewees. This area has gotten considerable attention in other states and other groups studying the benefits of technology. Even simplifying enrollment requirements without technology can improve access to care.
Electronic medical record (EMR)	One private sector health care organization has commissioned a task force to look at EMR possibilities. Others expressed	Fragmented record of care. No record available when patient presents for treatment. Documentation for claims	Improved continuity of care, access, treatment and payment.	Secure electronic communications must precede EMR. Those organizations that have established internal communications have more options to develop applications e.g. EMR. The DATA Warehousing

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Administrative Simplification Initiative	Description	Administrative Burden	Purpose or expected Outcome	Comments
	interest but felt EMRs were not yet a practical solution.	processing not readily available.		efforts noted above are, in some cases, a less sophisticated attempt to get to the same end, i.e. an electronic record of treatment. Privacy concerns are an issue.
HIPAA compliance	Organizations working together to develop solutions to HIPAA requirements, including such things as consent forms and privacy notices.	The burden of each organization developing its own HIPAA response is resource-intensive and time consuming. Business associate agreements, privacy notices and other forms must be developed, in addition to required training and position descriptions.	If covered entities can take advantage of "lessons learned" and act together they may be able to reduce the cost and improve the effectiveness of HIPAA implementation. Meeting implementation deadlines with minimal pain and resource expenditure.	The goals of HIPAA are seen as laudable, but the implementation is frightening for many. A concern was expressed that HIPAA could undermine the move to e-commerce as providers return to paper and phones to avoid HIPAA. Organizations, particularly small organizations, feel they do not have clear guidance about how best to implement HIPAA. Several private sector representatives expressed interest in rulings by the state Attorney General's office on where HIPAA does or does not apply.
New public-private partnership model	One private sector organization is exploring new ways of interacting with the state that would be more collaborative and less competitive.	The current method of Request for Proposal and ensuing contracting inserts administrative processes onto the desired products. These burdens can sometimes be costly in dollars and delay.	More collaborative public-private work processes; potential to reduce costs/improve turn around time. Overall satisfaction of working together across the two sectors.	
On-line support for referrals and pre-authorizations	The ability to send consults electronically and have referrals and treatments pre-authorized for payment.	Referrals now may be mailed or faxed to specialists, sometimes causing delay in treatment and/or payment. Treatment may be received and later denied as unauthorized.	Improved access and payment. Increased patient and provider satisfaction.	
Rural health care organizations Administrative Simplification issues	As part of a larger grant project, Choice Regional Health Network is identifying issues of concern to rural health care operations and developing standardized approaches and assistance for HIPAA implementation at small health organizations.	Rural health care organizations have special needs and processes not addressed by the more global guidelines for larger, or even small but urban, entities.	Choice considers this the first step in an ongoing effort to address administrative issues of concern	
Secure electronic communications within a health care entity	Several organizations have established secure electronic communications across their health care delivery network. The communication infrastructure may be internally developed or outsourced to commercial entities (e.g. Pointshare).	Inability to transmit electronic data in a secure fashion. Limits business efficiency.	With the secure communications infrastructure in place, health care organizations can share data throughout their business and begin to develop applications such as enrollment and eligibility checking, claims processing, and electronic medical records.	

Administrative Simplification Initiative	Description	Administrative Burden	Purpose or expected Outcome	Comments
Secure electronic communications statewide across the private sector	The Network Advisory Group (NAG) & the Washington Health Forum Services (WHFS), both entities of the CEO Forum, have launched an initiative to develop a secure communications infrastructure across their member organizations	As noted above, the same inability to communicate securely within an organization is magnified across organizations.	An infrastructure that allows development of ebusiness functions across the private health care sector. The ability to transmit data securely. This will provide the platform on which applications such as claims processing and secure email can be built. Potential to reduce reimbursement delay, improve communications between/among payers and providers.	More details of this initiative can be found in Appendix B.
Standardized coding	Representatives of public and private sector health entities are working together to standardize coding on claims and other documentation.	In addition to HIPAA requirements there are many unregulated codes. The variations can delay reimbursement and impact treatment and access.	Streamlined processing claims and other health care documentation requirements. Clearer, consistent coding would greatly assist health care system efficiency.	As a provider and major payer of services, the state can affect coding consistency and variability. Public representatives to sit on the various committees working on coding standards.
Streamlined credentialing	Mechanism to reduce multiple and variable credentialing requirements. Some initial efforts made by external organizations. A single provider database may be beneficial.	Multiple credentialing may be required, depending on the number of plans a provider participates in, the number of locations s/he operates from, and other variables. To maintain accurate and current credentialing information is time consuming and may negatively impact treatment and payment.	Reduced redundancy of requirements, improved provider availability and payment.	One interviewee refers to this as "provider eligibility" and notes the current process is overwhelming.
Structured approach to and prioritization of multiple administrative simplification projects	The Administrative Simplification Committee of the CEO Forum developed a structured process for setting priorities among administrative process improvement projects. Using eight criteria, 97 provider and health plan representatives identified simplification opportunities and ranked them for project planning	The 13 areas of administrative burden that provide opportunity for improvement are: 1. Streamline Referrals & Pre-Authorizations 2. Standard Adjudication Logic 3. Single Source Credentialing 4. Electronic Remittance Advice 5. Streamline Case Management Process and Utilization Review 6. Standard Appeals Process 7. Comply with HIPAA 8. Standard Benefit Description 9. Standard Audit Procedures 10. Standard Formulary 11. Standard Patient Communication 12. Standard Insurance Card 13. Single Provider Directory	Overall, reduced administrative inefficiencies, improved payment, treatment and access to health care.	Further details regarding the ASSC process, criteria, and project prioritization can be found in Appendix B.

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Technical Advisory Group and Follow-Up Interviews

Once the initial interviews were completed the Technical Advisory Group (TAG) was convened. The participants reviewed the initial inventory of initiatives and issues to distill the major ideas or guidance for state involvement in administrative simplification efforts: The direction from the TAG was that:

- The state should do something transformative, show leadership.
  - Specifically, participants suggested an initiative that would expedite small claims adjudication and payment.
- There is no appetite for regulation or standardization of a single technological approach.
- Internal collaboration (public-public) should precede external collaboration (public-private).
- The state needs to "come to the table" with one voice, rather than multiple voices of various state agencies.

The follow-up interviews were used to clarify earlier comments and issues. We were reminded that forms of administrative simplification are going on every day in the market and that there has been steady progress in many areas. In addition to the state's desire to support a broad collaborative initiative, taking advantage of what is already out there e.g. the state encouraging electronic claims submission, is also a useful strategy for the state to pursue.

Identification of Opportunities

We analyzed the findings from the interviews, the TAG, and follow-up discussions to identify opportunities in which the state could support or collaborate in administrative simplification efforts. Much of what was heard in the administrative simplification investigation mirrors that heard in the community access initiatives, benefits distillation, and other activities of the Washington State Planning Grant. The opportunities for state action described here are focused only on administrative simplification. The consultant team used the following guidelines to identify potential opportunities for state participation in or support for administrative simplification activities:

1. Select broad collaborative administrative efficiency efforts
2. Consider the overall effect of the initiative(s) in reducing administrative burdens
3. Identify barriers and potential state roles
4. Consider the interest of affected parties in a state role
5. Identify new areas ripe for initiatives

As a result, three areas are identified for consideration by the state:

- Support the efforts underway by the CEO Forum, Washington Health care Forum Services, and their Network Advisory and Administrative Simplification Groups
- Speak with one voice
- As a specific example of leadership and action to advance system change, establish an adjudication threshold for prospective screening of claims in state programs

Each of these areas requires varying degrees of additional investigation to determine the efficacy of implementation, and its statutory, regulatory, financial, and administrative feasibility. An initial high level exploration follows.

Many individual organizations and entities are taking innovative steps toward administrative simplification every day in the market, and progress has been made in many areas. The state should not ignore the opportunity to take advantage of what is already out there, for example requiring or encouraging electronic claims submission for participation in state funded programs.

I. Collaborate/Cooperate with the CEO Forum, Washington Health care Forum Services, and their Network Advisory and Administrative Simplification Groups

The CEO Forum, established in 1998, is composed of the major private payers and providers of care in Washington State. This coalition of competitors has agreed to cooperate and share knowledge (within legal limits) for the good of the health care system and patients throughout the state. The Forum established a Network Advisory Group (NAG) in 1999 and the Administrative Simplification Steering Committee (ASSC) in 2000 to identify and address opportunities to simplify the administration of health care. In March 2001, the forum took another large step and formed Washington Health care Forum Services (WHFS), a corporation with initial funding from the Washington State Hospital Association, the Washington State Medical Association, and the four major health plans in the state: First Choice Health, Group Health Cooperative, Regence Blue Shield, and Premera Blue Cross.

The Forum has separated the technology-centered activities from the administrative process identification and improvement opportunities. The ASSC has identified opportunities for process improvement, especially standardization of processes, which may or may not include a technology component. The NAG has as their objective to "implement electronic solutions for exchanging information between health plans and providers."

The ASSC developed a structured process for setting priorities among administrative process improvement projects. Using eight criteria, 97 provider and health plan representatives identified simplification opportunities and ranked them for project planning. These opportunities are noted in Figure 1 and further detail is provided in Appendix B.

Although many of these target opportunities are reflected in the data gathered through our interviews, the ASSC identified some priority opportunities that we did not, e.g. standard patient communications. Conversely, our interviewees identified some opportunities, such as enrollment and eligibility processes, as burdensome that were not included in the ASSC's twelve priorities.

Taking its lead from the same large group of provider and health plan representatives, the Network Advisory Group is moving forward in the following areas specific to electronic communications: data and transaction standards; and standard, secure connectivity and access. More detailed descriptions of the organization, its history, and its current initiatives can be found in Appendix B.

The state can explore opportunities to interact in one or both of these areas (that is, technical or process). The technology solution may benefit from state cooperation on digital certificates or related security and access issues. As the private sector begins to roll out a common, secure communications infrastructure, providers may find themselves with "private certificates" issued through Washington Health Forum Services and "public certificates" for Transact Washington, the Washington State Public Key Infrastructure used by state programs. The state can work with the Network Advisory Group and WHFS to ensure optimal methods of efficient certification across both sectors.

Real and immediate opportunities lie with the Administrative Simplification Steering Committee's process improvement initiatives. The ASSC has done much of the legwork needed to rank initiatives and identify changes or remediation activities. The group will use their

collaborative process to develop standardized processes for activities such as referrals and pre-authorizations (their highest priority) agreed to by the participants. The state could take a valuable first step by agreeing to review the uniform policies that have begun already to flow from the ASSC for use by the private community and to apply them to state programs where feasible.

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The state has the ability to implement some innovations more quickly than the commercial sector or to implement them across state health-related agencies. Using a non-health care process as example, car tabs could be issued at the time of emissions checks, if state agencies or programs within an agency shared data electronically. Similar knowledge-sharing opportunities may exist within state health care operations that would further enhance or support some of the ASSC's initiatives.

II. Speak with One Voice

Collaborating or cooperating with the CEO Forum is hampered, in the view of TAG members and interviewees, by one major barrier: the state too often presents itself not as a single entity or partner but as a number of separate, sometimes contradictory or uncoordinated voices on health care issues and policies. The Forum is not interested in discussing programs and policies with multiple state agencies, which it believes further complicates, rather than simplifies, administrative processes. CEO Forum members expressed hope that the Washington State Planning Grant will result in a yet-to-be-determined body that can provide that one state voice. Only after such a development would the Forum entertain the idea of committing resources and time to prototype cooperative efforts with the state.

This perspective was heard often in interviews, at the technical meetings, and at forums held for other components of the Washington State Planning Grant project (see, for example, Report 4.4 *Community Access Initiatives*). "No single place to ask questions about state programs; no one seems to have a definitive answer" was but one such comment. The examples of the administrative burden that these variations cause were frequent: multiple ways to determine eligibility and enrollment; one state agency returning claims because data elements controlled by other agencies are not current; the enormous training burden and staff costs of keeping up with the different requirements of different agencies.

These complexities are not unique to the public sector, but two factors highlight the concerns about the state's role in discussions of administrative simplification. First, the payment rates for public sector programs are markedly lower than private sector rates, providing fewer financial resources to pay for increasing administrative burdens. Combined with other forces affecting providers' economic well-being, this dissonance between payment and costs may threaten their viability. Second, the private sector has, in fact, formed a single body, The CEO Forum and its subsidiaries, to deal with just these issues. The state has not yet shown the same enterprise.

Interviewees acknowledged the complexity of health care, *per se,* and the need to administer various state programs—such as worker's compensation and Medicaid—in different ways. Yet the frustration with the lack of consistency and cross-agency communication was clear.

The consultant team identified three, interdependent levels of opportunity for the state to become more unified—policy, organizational and administrative.

The Policy Level. Are there state policies that vary across—or even within—agencies that result in administrative burdens? For instance, in the Yakima Valley Farm Workers Clinic, if a patient is enrolling in Basic Health, the determination of eligibility and subsequent enrollment can occur in the provider's office. However, if the patient is enrolling in Healthy Options, he or she must visit the Community Service Office, a separate location staffed by a state employee. Is this variation founded on statutory or regulatory requirement or could it be relieved by a policy change? Further data gathering to identify agency variation would be needed to determine the magnitude of this change.

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The Organizational Level. Are administrative procedures occurring in the most rational and effective manner? For example, one agency requires five data elements on its claim submission, but two of these elements are administered by another state agency. If these latter are out-of-date, the first agency rejects the claim and returns it to the originating provider or plan. But the provider/plan doesn't control these data elements and can't change them, so the claim information must be updated by the second agency before it can be re-submitted to the first. The result is both added "hassle factor" and delayed income. The first step in attempting to relieve these kinds of organizational issues is to understand the processes and document them for decision makers to consider. Borrowing from other industries, "business process re-engineering" begins with determining the "what is" so that the processes can be rationalized.

The Administrative Level. Using the example cited earlier, can the eligibility and enrollment functions of Healthy Options and Basic Health be simplified without policy changes? Are there other administrative annoyances that can be identified and remedied so that the state "speaks with one voice" in the administrative processes it requires of providers and health plans? The intent of each of these levels is administrative simplification; however, within this third level of opportunity are there "quick fixes" that might be identified and resolved without either policy alterations or more detailed business analysis.

On all fronts, communication enhancement could contribute positively to the "one voice" concept. Report 4.4 *Community Access Initiatives* discusses a proposal for a "Community Access Ombudsman Office." Although this is targeted as a single point of contact for the community and could act as a focus for issue resolution, it could also serve to improve knowledge across state agencies about what each is doing in terms of administrative simplification (or complexity).

The state has done this well in the past. More than one interviewee echoed the comment that "people got together to try and make [health care] work. When reform was gutted, people went back to their corners." The Interagency Quality Committee was one such forum that pulled together agencies and was a force for collaboration. Whether from lack of resources or lack of interest, this group disbanded. Perhaps this group or another of similar makeup could be re-engaged to enhance cross-agency understanding and work to advance public-private collaboration. "The state knows how to do this," said one interviewee, it just has to become a priority.

One thing that was made clear in the interviews and the TAG meeting: One voice *does not* mean regulatory requirements for technology standardization. The least valuable path for the state would be standardization of any single technological approach, in the view of private sector organizations and individuals.

Finding a way for the state to participate in, cooperate with, or support the CEO Forum and its efforts has the most potential to address the administrative burdens and simplify these processes across the entire health care system in Washington State. The first step is to determine how best to approach the Forum "with one voice."

III. Adjudication Threshold

The third and final area suggested for further investigation is an action that reflects the Washington State Planning Grant staff's—and the interviewees'—desires "*to do something transformative*." An initiative to streamline part of the claims adjudication process in public health insurance programs has the potential to relieve administrative burden and demonstrate state leadership.

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The frustration with claims processing and turn-around time is evident throughout the provider community. Often providers simply set a threshold below which it is more cost-effective to write off the claim than it is to process it. This further reduces their income and increases the possibility that in the future they will refuse to care for state beneficiaries and other low-income patients.

An idea introduced at the TAG meeting was greeted with enthusiasm by participants: claims below a certain dollar amount would be paid expeditiously without prospective adjudication. The idea was considered a possible transformational action on the part of the state that would have a positive effect on providers and a relatively minor impact on the state. A pilot project would be viewed as a good faith demonstration of the state's interest in reducing its part of the administrative burden in the health care system.

Currently all claims submitted must pass through filters and checkpoints as they proceed to payment, often resulting in long delays. Other industries get money into the hands of businesses/customers quickly, adjudicate retrospectively, and analyze data for problematic patterns. The credit card industry pays the bill, so that neither merchant nor customer is disadvantaged, and later determines a corrective course of action. That industry also identifies patterns of expenditures and can stop the use of the credit card if odd expenditures persist.

To leverage similar advantages, the state would examine historical claims data and distributions, perhaps of a single state program, to identify a threshold claim level that could be paid without prospective adjudication. For example, if 80 percent of claims are less than $100, but they account for only 20 percent of total expenditures, then claims up to $100 could be paid immediately. Retrospective profiling would expose system abusers and would set off different payment rules for these providers/plans.

Before such an initiative could be undertaken, a number of questions would need to be addressed to be able to understand why claims are paid slowly (is it lack of proper coding? Incomplete documentation?) and any financial impacts. By selecting a state program and analyzing data available from historical claims, knowledge could be gained regarding:

- How many total claims were filed?
- How many claims fell below different dollar amounts ($20, $50, $100)?
- What percentage of total dollar value do these claims represent?
- What is the current turn-around time on payment of these claims?
- What are the primary reasons for payment delays?
- What are the implications (information systems, workload, state budget, processes for retrospective corrective action, federal match) of moving to retrospective adjudication of these claims?

The goals of a threshold adjudication pilot project would be long-term reduction in cost of adjudication overhead, the ability to shift resources to more important and cost-beneficial tasks—both for the state and providers—improved trust and cooperation from providers, a greater willingness among providers to take state-supported patients, and improved access for state beneficiaries.

The state could initiate a pilot project in a single state health program. It would be important to manage the expectations of the project from the onset, since pilots are inherently of smaller scope with fewer benefits (and costs) than a full-scale project might be. Furthermore, the state

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program chosen might not be a significant part of providers' claims, so they might not see large changes in either income or administrative burden; in fact, providers might incur some initial training and processing costs. It will be important for the state to keep focused on the broader goals of the pilot project: take a leadership role, show that it could be done without negative results, and demonstrate a willingness to be innovative in crafting administrative simplification solutions.

The next steps needed to explore this concept include identifying a state program that would be willing to participate; collaborating with providers who would be affected; reviewing claims data for historical distribution patterns and determining an acceptable threshold; establishing baseline data for comparison after the pilot project is launched; and seeking other necessary partners (e.g., payers).

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Conclusion

The input we received from interview and advisory group participants identified administrative simplification initiatives and issues in the private sector. The staff of providers and payers, and patients themselves, create innovative ways to deal with the complexities of health care on a daily basis. However, the substantial administrative burdens in health care delivery—and from the perspective of some private sector representatives, state programs in particular—contribute both directly and indirectly, to diminished access for beneficiaries. The Washington State Planning Grant on Access to Health Insurance recognized this and invested energy and resources to understand these burdens and discover ways to work cooperatively with public-private initiatives to improve access to care.

The consultant team concludes that the one "broad, collaborative initiative" in the private sector with the participation of the right players with sufficient clout to devise and implement solutions is the CEO Forum and its subsidiaries - Washington Health care Forum Services, the Network Advisory Group, and the Administrative Simplification Steering Committee. A prerequisite for any significant collaboration with this private sector effort will be for the state to "speak with one voice," to find ways to maximize coordination and consistency among state health agencies and programs, their policies and processes, and their data reporting and regulatory requirements. Then, as a next step, the state can explore more specific activities that can be undertaken to support this coalition or to otherwise participate in its efforts.

Finally, we suggest one immediate example of an initiative the state could take in the short term. Either the Washington State Health Care Authority or Medical Assistance Administration could develop a pilot project to identify and implement a claims adjudication threshold. The goals of this effort would be to streamline the adjudication process by expediting payment of low-cost claims, improve providers' revenue flow, and send a signal that the state is a partner in efforts to reduce administrative burdens.

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Appendices

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B. Documentation from Private Sector Administrative Simplification Initiatives

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Part 1. Administration Simplification Steering Committee Opportunities and Process Description

Part 2. Network Advisory Group and HIPAA Forum Presentation Materials

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C. Interview Guide and Data Gathering Instrument (Washington State Planning Grant on Access to Health Insurance)

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Appendix A

Administrative Simplification Resources and References—An Annotated Bibliography

Academy for Health Services Research and Health Policy

www.academyhealth.org

The Academy for Health Services Research and Health Policy serves as the national program office for the Robert Wood Johnson Foundation's State Coverage Initiatives program. Their "State of the States" report as well as their monthly newsletter often contain information coverage that evaluates the connections between administrative complexity of health care programs and the cost, quality, and access to care, particularly of publicly insured beneficiaries.

In addition to its Web site above, it can be reached at 1801 K. St NW, Ste 701-L, Washington DC 20006-1301. Phone (202) 292-6700, e-mail info@ashrhp.org

Arkansas's Automated Eligibility Verification and Claims Submission system (AEVCS)

http://www.medicaid.state.ar.us/ArkansasMedicaid/GeneralMedicaidInfo/aevcs.htm

http://www.eds.com/case_studies/case_arkansas.shtml

Arkansas's AEVCS system was developed through the Arkansas Department of Human Services Division of Medical Services and EDS, Arkansas Medicaid fiscal agent. It was launched as a pilot in 1992 and now operates in more than 2,600 provider locations. It cites among its accomplishments: a reduction in claims processing time from 15 to 3.5 days, and claim denial reduction from 12 to1 percent. The director of the program for Arkansas reports providers are more willing to participate in the state Medicaid program because of the greatly improved cash flow.

Coalition for Affordable Quality Health care

www.caqh.org

CAQH is a coalition of 26 of the largest health plans and insurers in the United States as well as other related associations. Among their members: Aetna, Blue Cross Blue Shield, Cigna, Health Net, Group Health Cooperative of Puget Sound, the Health Insurance Association of America, Mutual of Omaha, Regence Group, and Wellpoint. Its three areas of focus are to improve access, advance care and safety, and simplify administration. Among its initiatives is the development of a national provider database that will contain credentials of over 600,000 providers and act as a single source for credentialing information.

In addition to its Web site above, it can be reached at: 1129 20th Street, NW, Suite 600, Washington, D.C. 20036, Phone (202) 861.1492, email info@caqh.org

Dunbrack, L. NaviMedix's NaviNet Web solution delivering measurable administrative simplification to neighborhood health plan. Managed Care Quarterly, 2000, Summer; 8(3):22-6.

This local initiative makes referrals, claims, and eligibility verification available via the Web to the providers in the Boston-based HMO. Initial outcome studies indicate a savings of three dollars for each dollar invested.

Foundation for Health Care Quality/Community Health Information Technology Alliance

www.qualityhealth.org www.chita.org

The Foundation for Health care Quality is a non-profit public-private partnership alliance founded in 1988 and operating out of Seattle Washington. It is "dedicated to serving the health information needs of the

community". The Foundation's Community Health Information Technology Alliance (CHITA) is specifically focused on e-business in health care, particularly on health care and technology companies in the Pacific Northwest market. Among its activities CHITA promotes education for HIPAA implementation and currently administers the HealthKey Program.

In addition to the Web sites above, the Foundation and CHITA can be reached at 705 Second Avenue, Suite 703, Seattle, WA 98104, phone (206) 682-2811.

Health Policy Analysis Program. 2001. State Primary Care Provider Study.

Conducted for the Washington State DSHS Medical Assistance Administration and Health Care Authority. Olympia, WA. This study of providers of primary care to low-income rural patients found that the financial distress of these providers and their increasing unwillingness to participate in public programs is linked to administrative overhead.

Kenney, Genevieve, Jennifer Haley, and Lisa Dubay. Why Aren't Uninsured Children Enrolling Medicaid and SCHIP. The Urban Institute, 2001.

Many people eligible for public programs remain uninsured. The authors found the number one reason to be a lack of knowledge about the programs. Administrative complexity was sited as the reason the children were not enrolled by 9.5 percent of those surveyed.

Minnesota Center for Health care Electronic Commerce

www.mhdi.org/mchec

The Minnesota Center for Health care Electronic Commerce is an alliance of private organizations and public agencies focused on promoting health care information technology and electronic data interchange statewide throughout the health care system. Among its current project: establishing a Public Key Infrastructure (one of the HealthKey project sites), educating and training for data standards, and online enrollment and eligibility.

In addition to the Web site above it can be reached through the Minnesota Health Data Institute at 2550 University Avenue West, Suite 345 North, St. Paul, MN 55114, phone (651) 917-6700, e-mail info@mhdi.org

The National HealthKey Collaborative

www.healthkey.org

HealthKey is an initiative launched in November 1999 with initial funding from The Robert Wood Johnsen Foundation. Its membership is composed of nonprofit, community-based organizations with a shared interest in developing standardized electronic health security solutions. It has a particular focus on the development of Public Key Infrastructures (PKI) and projects related to this in several states. (PKI is a methodology that combines encryption, authentication, and architecture to enable secure exchange of electronic data).

The National Committee for Vital Health Statistics

www.ncvhs.hhs.gov

The National Committee for Vital Health Statistics serves as an advisory body to the Secretary of Health and Human Services. The committee is composed of 18 individuals from the private sector with expertise in health statistics, electronic interchange of health information, privacy and security of data, and epidemiology, among other things. They have been particularly active in reviewing the HIPAA legislation and recommending changes.

Parry, Michael, et al. Medicaid and Children: Overcoming Barriers to Enrollment, January 2000. Conducted for the Kaiser Family Foundation.

Like the study from The Urban Institute, this report documents the difficulties parents experience when trying to enroll their Medicaid-eligible children. Twenty-one percent of those surveyed found the complexity of the administrative processes sufficient to deter their successful enrollment.

Utah Health Information Network

www.uhin.org

The Utah Health Information Network (UHIN),with a mission to lower overall costs for users of health care in Utah, focuses on establishing methods for electronic health care transaction exchange. Its membership is composed of health care insurers, providers, other related private organizations, and state agencies. It acts as a hub for the electronic exchange of health care claims and remittance advice and is currently working on projects such as instant eligibility determinations and a centralized health information repository.

In addition to the Web site above it can be reached at 1939 South 300 West, Suite 186-11, Salt Lake City, Utah 84115, phone (801) 466-7705.

Western Governors' Association

www.westgov.org

The Western Governors Association is an association of the governors of 18 states and three U.S.-Flag islands in the Pacific. These governors work together to address key issues in natural resources, the environment, human services, economic development, international relations, and public management. It launched its Health Passport Project three years ago. This project tests the use of smart card technology to enable the availability of health care information and to improve public health. The cards were issued primarily to lower-income working families in three states during Phase I and were used to obtain health care in Medicaid, Health Start, and Maternal and Child Services, among others.

In addition to the Web site above, it can be reached at: 1515 Cleveland Place, Suite 200, Denver, CO 80202-5114. Phone (303) 623-9378.

Workgroup for Electronic Data Interchange

www.wedi.org

The Workgroup for Electronic Data Interchange (WEDI) is a membership association of providers, payers, government organizations, vendors, and individuals whose mission is to "foster widespread support for the adoption of electronic commerce within health care." WEDI, through their Strategic National Implementation Process (SNIP), has become particularly influential in assessing HIPAA readiness throughout the health care industry. It provides national education forums and identifies areas to target for change or resolution as the HIPAA standards roll out.

In addition to the Web site above, it can be reached at 12020 Sunrise Valley Dr., Suite 100, Reston, VA. 20191, phone (703) 391-2716.

Appendix B
Documentation from Private Sector Initiatives

Introduction

The products in this appendix illustrate and document selected private sector administrative simplification initiatives in Washington State. Materials were provided by the Administrative Simplification Steering Committee of the CEO Forum, the CEO Forum's Network Advisory Group and the Choice Regional Health Network in Olympia Washington.

Part 1. Administration Simplification Steering Committee Opportunities and Description of process

The ASSC information contained here was developed for internal use and is used here with permission. The Process for Ongoing Collaboration describes the formalization of the process developed to identify and assess administrative burdens and projects. This is followed by graphic illustrations of the findings and a narrative description of the same with a summary matrix.

Formalize a Process for Ongoing Collaboration to Achieve Administrative Simplification

Executive Summary:

Health care organizations are participating in a collaborative process to simplify the administration of health care delivery. The resulting projects represent good first steps, but the process must continue in order to make significant and sustainable impact. To date, participation has been on an ad-hoc basis. The process should be formalized to ensure commitment by organizations and continuity in staff participation.

A Formalize a Process for On-going Collaboration Project will recommend structures, roles, responsibilities and budget for an on-going process. It will also suggest internal staff management practices for consideration by participating organizations. These recommendations will be presented to the CEO Forum for their review, revision and approval. Steering Committee members will accomplish the bulk of the work.

Opportunity Statement:

Thirty-six representatives from 4 health plan and 14 practitioner organizations have tested out a collaborative process for identifying and addressing opportunities to simplify the administration of health care delivery. The process has taken shape and been refined over the course of events and has resulted in specific, doable projects that will simplify operational processes in the areas of Referral & PreAuthorization, Credentialing and Adjudication. These projects represent a first of many steps that must be taken to make a significant impact on the complexity that exists today. Formalization of the process is recommended in order to sustain the progress that we are just beginning to see.

This collaborative process has operated outside of the organizational structure of any single organization. Organizational support and operational neutrality have been key to its success.

Continued success of this effort will require an ongoing commitment from participating organizations to staff this initiative. Staff from participating organizations are required to direct and oversee the initiative, to engage in collaborative work groups, and to be change agents within each organization. Staff will be motivated to contribute on an on-going basis to the extent that their efforts are an integral and important part of their work responsibilities within their organization.

This collaborative process needs to be formalized to encourage staff participation and to maintain continuity in staffing, where and as it's important. Process scope also needs to be set in terms of breadth and type of organizations that will participate and how the results will be communicated to the broad health care community.

Possible Solution:

The Administrative Simplification Steering Committee will take responsibility for analyzing alternatives and making recommendations to the CEO Forum about how the process should be formalized. Considerations to be addressed include, but may not be limited to:

- *Organization, Membership and Role of the Steering Committee* in terms of monitoring ongoing projects, identifying new projects, ensuring that agreed upon changes stay synchronized across organizations.
- *Participation by an expanded scope of organizations* such as additional health plans, reference laboratories, pharmacies, etc. Broad-based participation will ensure that changes will take hold across the community.
- *Organization, Membership and Role of Work Groups* in terms of their accountability (to the Steering Committee and to their home organization) and ground rules for participation
- *Recognition of required level of staff effort* by incorporating work group participation as part of job description and performance review criteria within participating organizations.
- *Process Cost* to be shared by sponsoring organizations on an annualized basis
- *Communication of work results* to the broad health care community

The CEO Forum and sponsoring organizations will review the recommendations and make refinements that are necessary for their adoption.

Expected Benefits:

The expected benefits of formalizing the collaborative process are:

- Organizations can make staffing commitments with a clear understanding of expectations.
- Staff will have a clear message about the importance of their involvement in the process, including facilitating change within their home organization.
- Other health care organizations will know their path for participation and contribution.
- Project learning and results will be communicated for maximum benefit.

Proposed Project:

A Formalize a Process for Ongoing Collaboration Project will be conducted. The objectives of this project are to evaluate, recommend, and formalize how the ongoing process of collaboration

will be managed. This includes process organization, roles, responsibilities, and breadth of participation as well as practices that organizations can implement to support the process.

This project and all work related to it will be conducted in a manner that maintains the competitive practices of each health plan and practitioner organization, and the non-disclosure of proprietary and confidential information.

The Steering Committee will:

- Clarify process considerations (those above and others).
- Evaluate alternative approaches in terms of minimizing administrative overhead and maximizing productivity.
- Consider the impact on the process and on participating organizations.
- Consider cost implications
- Recommend process structure & expectations
- Recommend how participating organizations might allocate staff to this process

Project Approach, Milestones, and Timeframes

A Formalize a Process for Ongoing Collaboration Project will be will be initiated and endorsed by the participating health plans, WSHA and WSMA (sponsoring organizations). The Administrative Simplification Steering Committee will conduct the project. The CEO Forum will review, revise, and adopt recommendations.

Activity	Description	Timeframe
Evaluate Alternative Approaches and Recommend a Formal Process	• The Steering Committee will clarify the considerations and will evaluate alternative approaches for incorporating them into a formal process (1-2 group meetings) • In between Steering Committee meetings, members will work within their organizations to determine what is feasible. • The Steering Committee will propose specific recommendations and present them to the CEO Forum • (2-3 group meetings)	90 days
Refine Process based upon CEO Feedback	• The CEO Forum will review the recommendations and suggest revisions. • The Steering Committee will revise recommendations and resubmit to the CEO Forum • (1 meeting)	30 days

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Administration Simplification Steering Committee (ASSC) Process and Findings

Process . . .

-1-

Administrative Simplification Steering Committee (ASSC) of the CEO Forum

Results of the Evaluation Process with the BIG group . . .

Simplification Opportunities	Pri. (#)	Win-Win [1]	Sig. Relief [1]	Exp. Pay [2]	Affect Patient	Local Impact	Lever-aged	Total Score	Groups [3]
Streamline Referrals & Pre Auth	1	H	H	H	H	H	H	162	4 - 4
Standard Adjudication Logic	2	M [4]	M [4]	H	M	H	L	143	4 - 4
Single Source Credentialing (includes Provider Directory)	3	H [5]	H [5]	M	L	H	H	108	4 - 3
Electronic Remittance Advice	4	H [6]	H	H	L	H	H	99	3 - 3
Streamline Case Mgmt / UR	5	M [4]	M [4]	M	L	H	L	31	0 - 4
Standard Appeals Process	6	M [4]	M	H	M	H	L	41	3 - 3
Comply with HIPAA	7							12	0 - 2
Standard Benefits Description	8							11	2 - 0
Standard Audit Procedures	9							5	0 - 1
Standard Formulary	10							5	1 - 0
Standard Patient Comm.	11							4	0 - 1
Standard Insurance Card	12							0	0 - 0

In evaluating solutions, we need to consider the criteria 'Value Return' & 'Quick Win'

-2-

Administrative Simplification Steering Committee (ASSC) of the CEO Forum

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ASSC Process (continued)

Project Selection Criteria:

1. *Win-Win*: Impacts multiple Providers and multiple Plans.
2. *Significant Relief*: Addresses a high cost, volume and/or frequency headache.
3. *Expedite Payment Processing*: Reduces the time and/or effort to get claims processed and resolved.
4. Affects Patients: Improves the patient's experience
5. *Local Impact will make a difference*: Local plans can make an impact without involvement of national plans or public agencies.
6. *Leveraged*: Can leverage, and not duplicate, other efforts that are underway
7. *Value Return*: The value returned will be worth the investment in the solution.
8. *Quick Win*: The solution can be implemented quickly (3-6 months).

-3- Administrative Simplification Steering Committee (ASSC) of the CEO Forum

Legend:

- H M L
- *1 - The Steering Committee is most interested in recommending projects that have a 'High' Rating.
- *2 - The Steering Committee would like to recommend at least one project that has a Med-High Rating.
- *3 - Number of workgroups that rated the opportunity (Physician - Hospital)
- *4 - Higher for providers, lower for plans
- *5 - Higher for health plans and physicians, lower for hospitals

-4- Administrative Simplification Steering Committee (ASSC) of the CEO Forum

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Administrative Simplification Steering Committee Findings and Matrix

1. Thirteen simplification opportunities were identified. There seems to be general agreement about the priorities for addressing these opportunities. The only exception is 'Streamline Case Management Process and Utilization Review'. This opportunity pertains to hospital organizations and not physician organizations.
2. If "upstream" processes are simplified, the "downstream" process may not present as great a problem. For example, if the number of referrals and other services that require authorizations are reduced, fewer claims would reject and there would be fewer appeals (see Operational Flow Diagram).
3. For a number of opportunities, possible improvements were suggested. These, and other improvement ideas, will need to be evaluated to determine what is doable, what will have the most impact and in what timeframe.
4. The providers encourage the plans to work together to implement HIPAA required procedures that will impact the providers.

This group suggests that business and operational issues are considered and addressed as part of the process of implementing electronic transactions. Electronic solutions need to be affordable to provider organizations. There was no discussion about provider readiness for electronic solutions or the conditions under which they would be willing to pay for these solutions.

Administrative Simplification Steering Committee Findings: Matrix

Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
Streamline Referrals & Pre-Authorizations	Agree upon standard procedures for: Submitting requests to health plans for referrals and pre-authorizations Retrieving authorization information about submitted requests	Decrease time spent communicating referral information Improve experience of patient and consulting caregiver Reduce pending and denied claims (reduce timeframes of later steps)	Agree upon definitions and semantics (pre-auth, pre-cert, referral, authorization vs. payment guarantee) Agree upon a common 'short list' of services that require authorizations (or every plan could have their own very short 'short list') Auto adjudicate these services whenever possible. Agree upon common data elements and a standard submission and notification process. (Ideally, plans will accept the different forms that are generated by the different practice management systems as long as they contain the standard data set.) Develop guides about the process for education purposes. This would include who do providers call for what and which plans require. authorizations and which don't. Agree upon timeframe expectation for how long processing will take	Referral may be easier to auto-adjudicate than pre-authorizations
Standard Adjudication Logic	Agree upon standard guidelines/edits for adjudicating claims	Increase cash flow to providers Reduce time providers spend figuring out what to send to each plan and tracking it down	Agree upon standard criteria and procedures for pending and/or denying claims (e.g., CCI, etc.) Educate providers about the pending process Disclose proprietary edits Process secondary claims in a standard manner Implement a standard case rate methodology for outpatients	A possible win for plans if the number of appeals are reduced. Improvement ideas need to be carefully selected and defined. Information system changes may be an impediment. Focus should be on processes.
Single Source Credentialing	Develop and implement a single, standard credentialing application and process that will be used by providers and health plans	Reduce time physicians spend completing forms Reduce time health plans and hospitals spend going through the process of credentialing physicians	A "quick-win" may be for plans to accept claims from approved providers as of 'credentialing submission date' rather than 'credentialing approval date.' Providers would hold claims until approval, then submit and be entitled to payment retroactive to the	Work on timeliness of processes first. Single source could be later. Consolidate with the Provider Directory

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Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
		process of credentialing physicians Save printing and mailing costs	submit date. Endorse application developed by Washington Credentialing Standards Group (WCSG) Endorse work underway by WCSG to agree upon and implement a process and infrastructure for managing credentialing information at a single point Standardize requirements for which provider types need credentialing	Provider Directory Opportunity
Electronic Remittance Advice	Implement an electronic process for exchanging remittance advice information	Reduce time provider spend posting remittance information into their information systems		Smaller hospitals and smaller physician practices may not have necessary technology HIPAA has guidelines for implementing the electronic transactions
Streamline Case Management Process and Utilization Review	Agree upon standard procedures for managing inpatient cases and communicating authorization information in a timely manner	Reduce time hospital staff spends trying to get services authorized	Publish authorization criteria Publish authorization expectations related to issues such as medical necessity Agree upon process and timeframe for communicating what is authorized.	
Standard Appeals Process	Agree upon standard procedures for handling and communicating information about claims that have been pended or denied.	Increase cash flow to providers Reduce time providers spend following up on previously submitted claims	Standardize what information is necessary to appeal, what are filing timeframes, etc. Plans disclose their procedures about what information is needed and why	Win for providers. May be a quick win to implement. Smoother front-end processes may lead to fewer back-end denials. In that case this would become of less importance
Comply with HIPAA	Develop common approaches for meeting HIPAA requirements, e.g. privacy policies, business associate agreements, electronic identifiers.		Reach consensus on priorities for working together Coordinate closely with NAG	

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Opportunity	Description	Simplification Impact	Suggested Ideas	Comments
Standard Benefit Descriptions	Agree upon standard benefit descriptions that will be used by all health plans.			
Standard Audit Procedures	Agree upon a standard process for how health plans will audit clinical records that are maintained by providers. This includes expectations about how much notice of the upcoming audit will be provided, length of time to conduct the audit, and timeframe to communicate audit results.		Could a single time be set aside to do audits for all plans Transaction audit – plans review chart documentation related to specific event(s) Non transaction audit – plans review chart documentation to assess quality of clinical process (as defined by HEDIS, credentialing requirements, etc.)	
Standard Formulary	Develop a standard formulary. This may be a master formulary (compilation of the different formularies used by the various plans) or a common formulary (one formulary used by all plans).		Republish the "parallel" formulary (AWHP) which lists the various plans' formularies side-by-side within a drug class	Very big issue and difficult to solve
Standard Patient Communication	Develop communication materials that can be distributed to patients that will answer common questions related to eligibility coverage, benefits, referral procedures, case management process and general terminology.		Standard materials for patients and "road show" to providers	
Standard Insurance Card	Agree upon a standard for what information will be printed on an insurance card and how it will be displayed (e.g. health plan, program, billing address, contact information, PCP, physician network)		Find affordable ways for providers to get correct information about a patient's insurance coverage.	Some plans moving away from issuing cards The Blue plans have formatting standards
Single Provider Directory	Develop and keep current a provider directory that is accessible by providers and health plans			Consolidate with Single Source Credentialing

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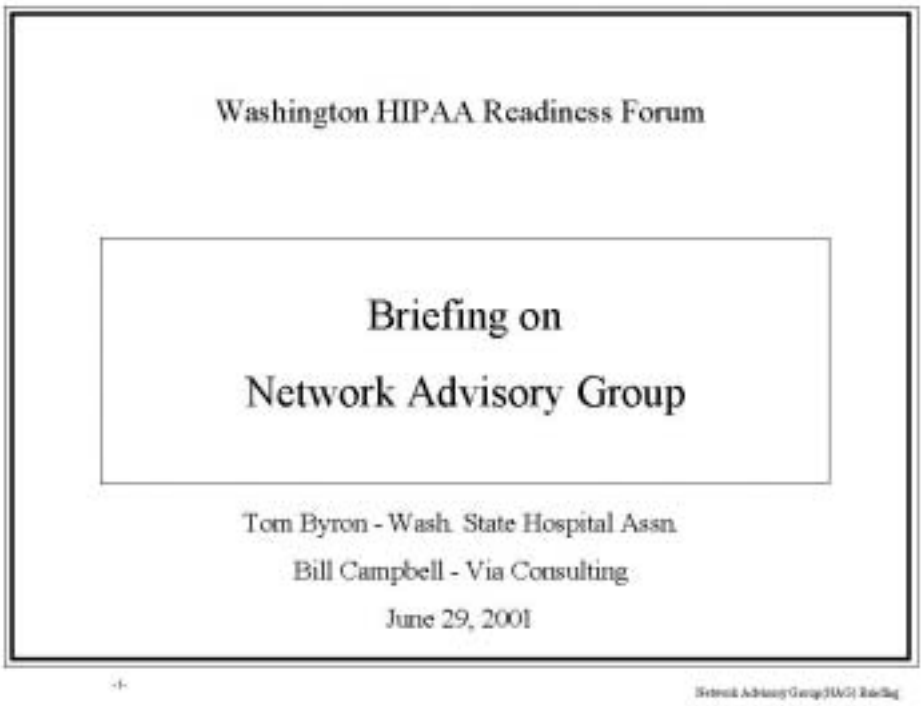
Appendix B, Part 2. Network Advisory Group HIPAA Forum Presentation

The Network Advisory Group of the CEO Forum and its business arm, The Washington Health Forum Services (WHFS), have launched an initiative to establish a secure communications infrastructure across their member organizations. The following slides, presented at the June 2001 CHITA HIPAA Readiness Forum, describe this initiative.



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Appendix B, Part 2. NAG Slides (continued)

Drivers

- CEO Communication
- Provider Concerns re:Increasing A/R Days
- Cost Containment Pressures
- HIPAA
- Emergence of Secure Internet Technologies

Chronology

- Early '98 - CEO Forum Established
- Fall '98 - Faster payment becomes assn. priority
- Jan. '99 - Prompt Pay legislation introduced in Wash.
- Jan., '99 - Wash. Ins. Comm. expresses interest
- April, '99 - CEO Forum Agrees on Cooperative Approach
- June, '99 - First meeting of NAG
- Aug., '99 - FirstChoice joins NAG

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Appendix B, Part 2. NAG Slides (continued)

Chronology

- June, '2000 - FirstChoice eligibility goes live
- Aug., '2000 - Group Health eligibility goes live
- Aug., '2000 - Premera eligibility goes live
- Nov., 2000 - CEO's approve Phase II work plan
- Feb., 2001 - Regence eligibility goes live
- March, '2001 - CEOs form Wash. Healthcare Forum Services

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Ground Rules for health plan and provider collaboration

- We seek system efficiencies
- We seek greater electronic interchange
- We will use a consensus building process
- We will commit necessary internal resources
- We will share facilitation fees

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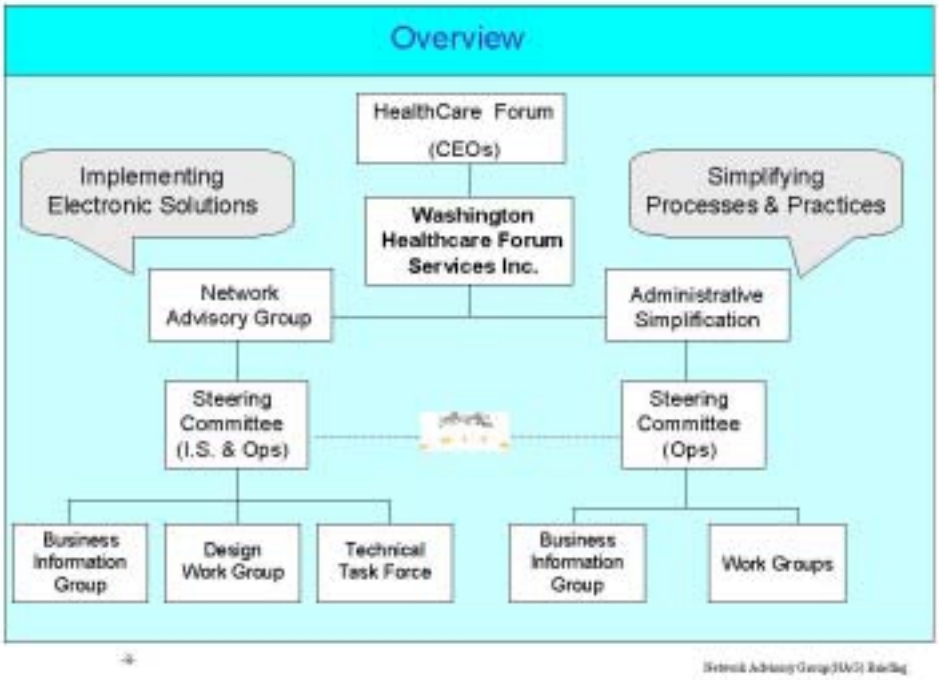
Appendix B, Part 2. NAG Slides (continued)

Structure

- Overview
- Washington Healthcare Forum & WHF Services
- Network Advisory Group



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Appendix B, Part 2. NAG Slides (continued)

Washington Healthcare Forum & WHF Services

- Funding Organizations
  - Provider: WSHA & WSMA
  - Health Plan: First Choice, GHC, Premera, Regence
- Washington Healthcare Forum & WHF Services

– Tom Curry	– WSMA
– Leo Greenawalt	– WSHA
– Gary Gannaway	– First Choice
– Cheryl Scott	– Group Health Cooperative
– Gubby Barlow	– Premera
– Mary McWilliams	– Regence
– Richard Cooper	– Everett Clinic
– Dr. Mark Adams	– Practicing Physician
– Dr. John Coster	– Providence Health System
– Richard Umbdenstock	– Providence Services
– Richard Peterson	– Swedish

Network Advisory Group

- NAG Steering Committee

– Bob Perna	– WSMA
– Tom Byron	– WSHA
– Robb Menaul	– WSHA
– Kevin McCroskey	– First Choice
– Janice Newell	– Group Health Cooperative
– Joel Suelzle	– Group Health Cooperative
– Alan Smit	– Premera
– John Holtermann	– Regence

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Appendix B, Part 2. NAG Slides (continued)

Our Objective -- Implement electronic solutions for exchanging information between health plans and providers

- Develop solutions that have measurable benefits when used by providers and plans
  - Take costs out of the systems
  - Improve cash flow (from time of transaction to payment)
  - Increase overall efficiency
    - Reduce phone calls
    - Increase speed of processing
    - Improve quality of information
    - Increase staff productivity
- Comply with HIPAA
- Get adoption and use by providers

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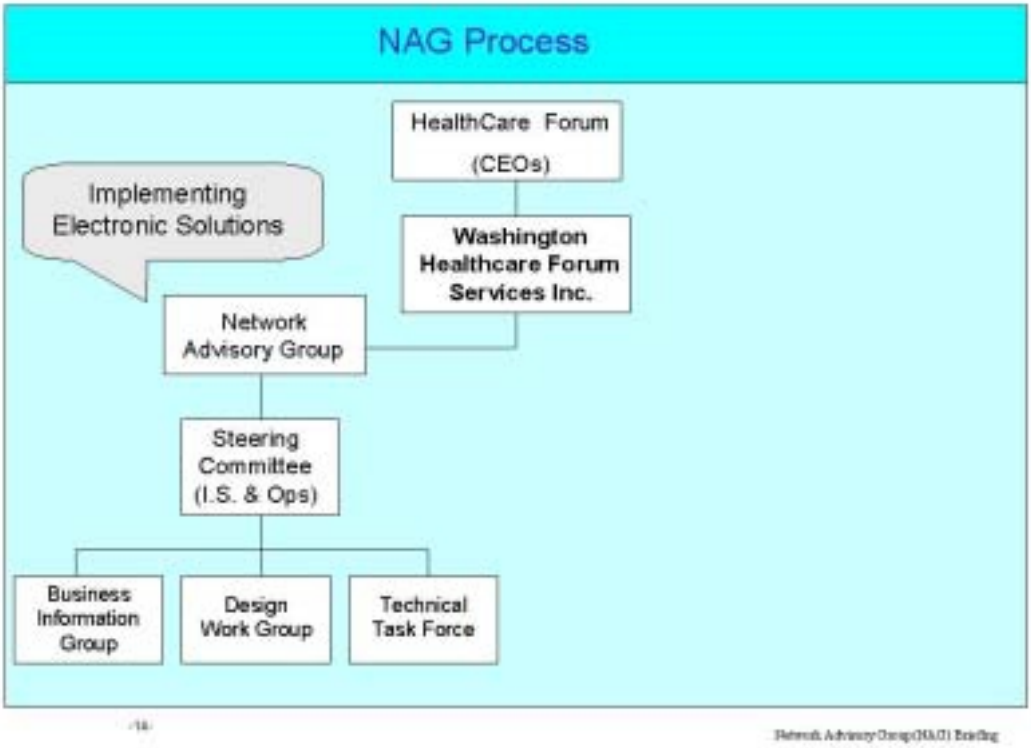
Appendix B, Part 2. NAG Slides (continued)

Initial Activity aimed at a "Proof of Concept"

- HIPAA compliant eligibility inquiry & response
- Start with a single intermediary - Pointshare
- Build trust among entities
- Establish a foundation & process for further activities
- Test idea of collaboration among competitors



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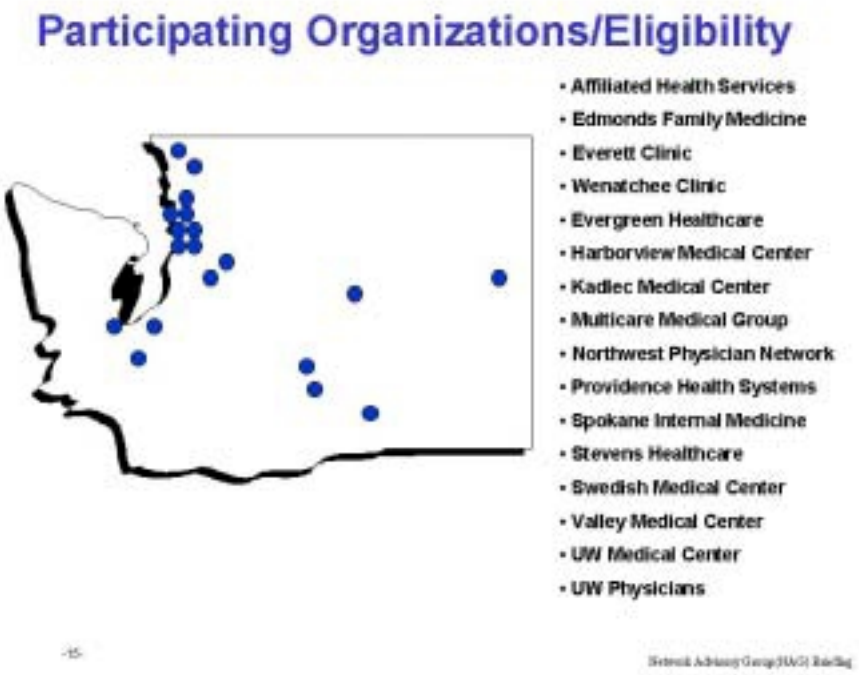
Appendix B, Part 2. NAG Slides (continued)



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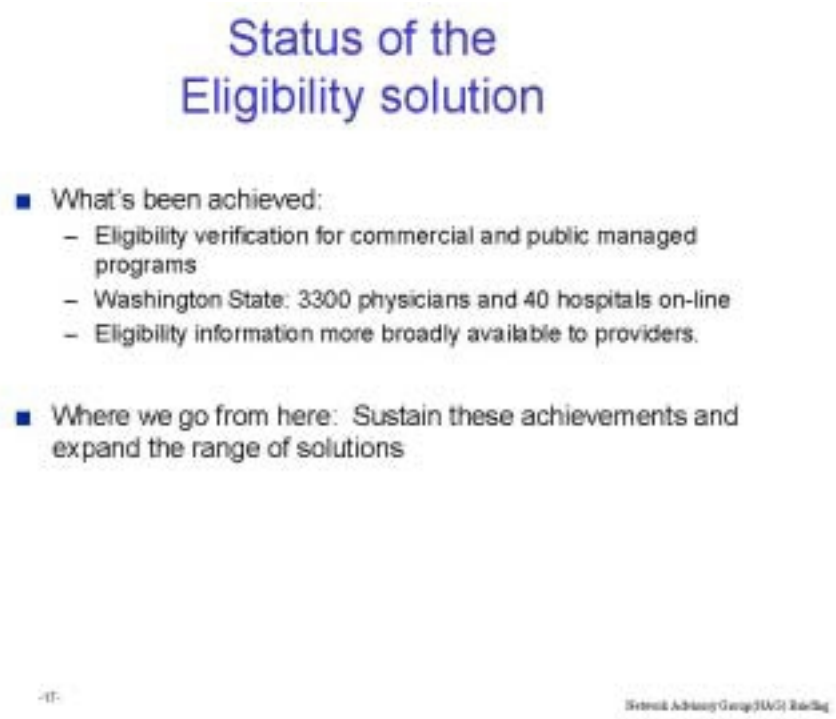
Appendix B, Part 2. NAG Slides (continued)



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Phase II - Further Standardization

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Network Advisory Group (NAG) Briefing

In December 2000, we kicked off Phase II to collaboratively standardize four additional transactions.

HIPAA MANDATES	Collaborative Design Dec Jan Feb Mar Apr May Jun	Independent Implementation Jul Aug Sep Oct Nov Dec Jan
Batch Eligibility Claims Status Referrals & Prior Auth Benefits	Collaborative design activities: • identify requirements • define solutions • agree on standards	Health Plans will implement these solutions in conjunction with their aggressive efforts to become HIPAA compliant

December - January

- Define Health Plans' questions for Providers
- Schedule and Prepare Big Meeting to hear provider's perspective
- Conduct BIG meeting on January 30th

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Network Advisory Group (NAG) Briefing

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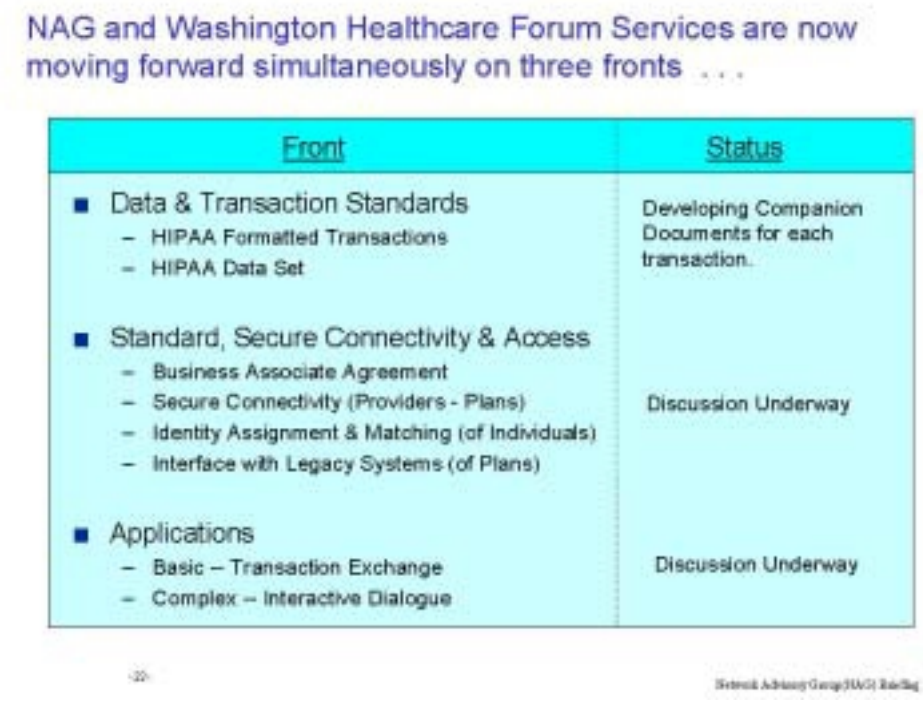
Appendix B, Part 2. NAG Slides (continued)



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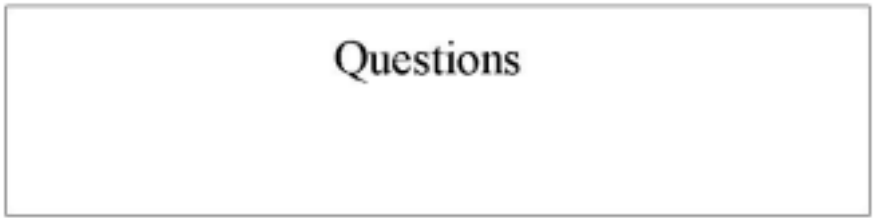
Appendix B, Part 2. NAG Slides (continued)



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Appendix B, Part 3. Choice Regional Health Network Matrix of Administrative Complexities

The following matrix is a “work in progress" as part of the 100% Access Demonstration Project being carried out by a collaborative convened by CHOICE Regional Health Network, Olympia, Washington, with financial support from a Community Access Program grant from the federal Health Resources and Services Administration. The work seeks to identify administrative complexities, especially those burdensome to small and rural health care providers.

Health Care Administrative Complexities Affecting Providers and Low-Income Patients/Clients

Summary and Worksheet

This table summarizes information from many sources including CHOICE’s provider forums in late 2000—early 2001 and professional literature.

Directions to participants: In the “check marks” column please mark those complexities/hassles that stand out for one of these reasons:

Mark with a * those that have high impact in your experience.

Mark with a ✓ those that probably started with legitimate administrative needs (although requirements have become too elaborate).

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Appendix B, Part 3. CHOICE Regional Health Network Matrix of Administrative Complexities (continued)

What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
A. Health plan Contracting Practices *Providers*	Plans may change providers on an annual cycle, increasing the providers' financial uncertainties and displacing their patients. Health plans compete for market share with proprietary administrative structures. This complicates provider participation even if the goals are positive (e.g., chronic disease management). Plans often update complex administrative rules annually, forcing providers to modify practices. The contracts providers are asked to sign are complex. Providers are challenged to understand provisions (including cancellation and "hold harmless" clauses) and the risks they present. Reimbursement methodologies in contracts (including carve outs, withholds, etc) may be complex or poorly defined, making it hard for providers to estimate risk and return. It is hard for clients to figure out which providers are contracted with what plans. Provider lists often are outdated and are not accurate about who is really accepting new clients. Specialty care may not be contracted locally in all counties. *Patients/Clients* When plans leave a county or drop providers, patients may have to change providers and health plans mid-treatment and lose continuity of care/medical home.		
B. Government Purchasing Practices	Washington State has pursued a strategy of managed care contracting for much state-subsidized health care. This means that changes in state benefits and policies are carried out through a process of Request for Proposal, health plan bids, contract finalization between the state and plans, and different detailed implementation within each plan.		

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What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
Providers *Patients/Clients*	Beyond Healthy Options and Basic Health, there are many special health programs with different purposes and requirements. Many changes occur every year due to new state laws or regulations, federal mandates, budget provisions, or administrative approaches. The Medicare program is run by the federal government and its contracted fiscal intermediaries and health plans, creating two levels of administration. Under the Basic Health Program's "managed competition" approach, enrollees choose plans with different premiums depending on the plan's cost to the state. If enrollees follow yearly changes in lowest-priced plans, they may need to switch health plans and often PCPs. Managed care contracting adds to the number and significance of decisions that clients must make. Crucial information arriving in a letter from "the state" (in English) may not be read or understood.		
C. Coverage and Benefits *Providers*	There are a multitude of different benefit packages. State programs are different in what they cover. A single private insurance carrier may have hundreds of different health insurance contract forms with major or minor differences in coverage. Some state programs are very specialized – for example, covering only work related injuries and diseases (Worker's Compensation), or only contraception, or only conditions related to HIV infection. For providers, keeping track of coverage differences is a major task. See Referrals and Pre-Authorizations for issues where advance approval is needed to provide or refer for a service. Choice of prescription drugs is generally subject to special restrictions. Drug formularies vary widely and do not always include the drugs practitioners view as necessary for quality or management of care. Enrollees often do not understand even basic aspects of what their benefits are, or what services are available through which program.		

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What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
C. Coverage and Benefits, cont'd *Patients/Clients*	Communication about benefits is often difficult to understand.		
D. Referrals and Pre-Authorization *Providers* *Patients/Clients*	In general, referral authorization is a complex and time-consuming process. Providers have had to add procedures and train staff to address referral requirements. Referral policies, forms, procedures, and requirements are not consistent among plans and purchasers. Some plans require a written referral for all services that are provided by anyone other than the PCP. Specialty providers also may be denied payment when a client is *referred* by the PCP but no *authorization* is sought for treatment. Changes to authorization rules are not always clearly communicated to the right people. Administrative structures don't support the managed care gatekeeper model; there is less focus on patient care integration than on utilization management. Referral does not always include all procedures provided at the time of service. Many times the original referral needs to be changed, and "by the rules" this often would require further communication with the plan. Verbal authorization may not be honored without documentation. Patients do not understand referral requirements. They may show up at the specialist's office without referral, which requires staff time and intervention to explain process for authorization. They also may not understand who is able to say yes or no.		

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What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
E. Determining Eligibility *Providers*	The risk for eligibility errors passes along from payers (employers or the state) to the health plans, then on to providers. For Medicaid – the state makes the initial eligibility determination, then notifies the health plan who sends the provider an eligibility list specific to that practice. Multiple state programs have different eligibility requirements, as well as separate application and enrollment processes. Clients can often change their PCP on a monthly basis, increasing the risk of eligibility errors. No mechanism is in place to ensure that the ID card presented to the provider at the point of service is current and valid. Eligibility, enrollment and disenrollment reports are not always accurate, leading to inaccurate claims and capitation payments. The electronic eligibility system (ENVOY) managed by Medicaid is not always up to date or accurate. Provided (and authorized) services are occasionally denied retrospectively due to a determination that the patient was not eligible. The provider may end up not getting paid. Data errors tend to work against providers. Plans receive premiums on a capitated basis but make payments based on accepted clean claims. (Example – a client chooses a clinic as their PCP, not an individual provider. The health plan receives payment from the state for that patient. When the eligibility lists are printed they are done by individual provider, not by clinic. In a capitated environment, the PCP would not be paid for this patient because of a clerical error.) Multiple state programs have different eligibility requirements, as well as separate application and enrollment processes. Having a coupon or plan ID card is not a guarantee of eligibility; services can be denied or postponed until eligibility is determined. Provided (authorized) services are occasionally denied retrospectively. The client may end up paying full cost of service.		

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What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
Patients/Clients			
F. Billing, Claims Payment and Collection of Patient Co-pays *Providers*	There is often a 60 to 90 day wait for claims payments, which may cause significant cash flow problems, especially for small practices. There is no general definition of a "clean claim." Claims payment data is slow and inaccurate, requiring staff time to research and resubmit. Claims that are resubmitted with additional information (after an initial denial) may be denied again as "untimely." Collecting co-pays and following up on claim payment problems require focused attention and a lot of time, challenging the abilities of many medical practices. See "Eligibility" for issues arising if coverage ends without the provider knowing (e.g., failure to pay premium, loss of program eligibility). Complex coding leads to errors. Coding schemes and changes are not always communicated in a timely fashion. Statements of services rendered to the clients are confusing, redundant, and often not easy to read, sometimes taking several phone calls and staff time to reconcile. Repeated submission of claims information, or requests for additional information, pose a difficult record-keeping challenge to keep track of what has been paid and what remains pending. Many claims adjudication software programs will reject a claim based on the first problem it finds. Payments may be tied up for months if the claim repeatedly returned to the provider, re-submitted with one error corrected, and denied again due to some other error. In a legalistic environment, demanding a correct paper trail can become an end in itself. Patients (or employers, who may hold the contract for coverage) often have no idea claims are being delayed or denied, affecting their providers' ability to provide care. If claims are denied, the provider office begins a collection process.		

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What (Burden) and Who is Affected	Examples of Complexities/Hassles From Current Health Care Administrative Processes	Check * or ✓ if desired (Directions)	Other major hassles that should be added to the list? Sources we should consult?
Patients/Clients	Delivery of care can be interrupted due to slow payment for services. Statements of services sent to clients are confusing, redundant, and often hard to read, sometimes taking several phone calls to reconcile.		
G. Credentialing Providers *Providers*	There are multiple licensing, credentialing, privileging and accreditation processes, often with different or overlapping requirements. The processes are redundant and error-prone. Some of the necessary information changes often, while other information could be verified once or infrequently. Site visit, facility and medical records review criteria are different for each health plan.		
H. Data Sharing, Submission and Reporting *Providers*	Claims submission and encounter data reporting are different for every health plan. HIPAA standards for electronic transactions will not by themselves guarantee the same technical implementation. Different proprietary systems being used to accumulate and process health care information. Inadequate data make it is difficult to link outcomes (including population health) to costs, or to promote sound fiscal policy and resource allocations at the provider's level. Data collected by health plans and government agencies is often not available to providers in a useful or timely manner. Sharing personal health information (PHI) for legitimate health care or administrative purposes is complex and subject to additional uncertainties due to new federal HIPAA rules. Business information that might contribute to better or more collaborative approaches sometimes cannot be shared easily due to proprietary or antitrust concerns. One-year contracts contribute to the difficulty of obtaining reliable and consistent trend data.		

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Appendix C

Interview Guide and Data Gathering Instrument (Washington State Planning Grant on Access to Health Insurance)

1. Name of interviewee:
2. Title and workplace:
3. Organization re: Administrative Simplification:
4. Role in Organization:
5. Recommended alternative/additional contacts:
6. Identification of the administrative simplification initiative (Name or label to which it is referred):
7. Description of initiative:
8. Other initiatives under discussion/needed/considered:
9. Leader/lead organization:
10. Participants in the initiative:
11. Location or locations of the initiative (single site, multiple sites):
12. Time Frame of initiative:
13. Problem initiative is designed to address:
14. Expected impact:
    a. Savings of time
    b. Savings of money
    c. Reduce duplication of resource use
    d. Overall ROI
    e. Examples
15. Intended assessment of the initiative:
    a. Anecdotal
    b. Evidence-based
    c. By whom
        i. In-house
        ii. Outside
        iii. Formal
16. Barriers/constraints:
    a. Government
        i. State
        ii. Federal
        iii. Other
    b. System-wide barriers

        Infrastructure – technical infrastructure

        i. Administrative infrastructure

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    c. Money
17. State government role:
    a. Current
    b. Potential
18. Follow-up opportunities:
    a. Primary point of contact
    b. Meetings/forum
19. Overlaps with other initiatives:
20. Category of administrative simplification—to be created from the results of the inventory:
21. Source of information regarding the initiative:

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